

EMS Aggregate Prehospital Report and Provider Profile Information Form *1

Provider ID Number: _____

Quarterly Reporting Period: _____

Report Year: _____

(Quarterly Reporting Period means the quarter in which the incident occurred.)

(Report Year refers to the year in which the incident occurred.)

**Part 1 - RUN INFORMATION FOR ALL RESPONSES WHERE THE EMS VEHICLE PHYSICALLY MOVED, THE PATIENT WALKED IN, OR WAS BROUGHT IN DIRECTLY TO THE EMS
Items 1 - 2 (TOTAL COUNTS) *2 *3 *4**

For Items 1-2, please record the total number of medical responses in the space provided below for this reporting period where the EMS vehicle physically moved, the patient walked in or, was brought in directly to the EMS provider (see Appendix A for specific item definitions).

1. Service Type Requested Choose 1 response per incident.	2. Incident/Patient Disposition Choose 1 response per incident.
Scene	Treated, Transported/General Hospital
Unscheduled Interfacility Transfer	Treated, Transported/Nursing Home
Scheduled Interfacility Transfer	Treated, Transported/Medical Office/Clinic
Standby	Treated, Transported/Home
Rendezvous	Treated, Transported/Trauma Center (Trauma Alert Only)
Not Applicable	Treated, Transported/Other
Unknown	Treated, Transferred Care
	Treated, Transported by Private Vehicle
	Treated, Released
	Treated, Refused Transport
	No Treatment Required
	Patient Refused Care
	Dead at Scene
	Cancelled
	Not Applicable
	Unknown
	No Patient Found
	DNRO (Do Not Resuscitate Order)

**Part 2 - INCIDENT/PATIENT INFORMATION FOR TREATED AND TRANSPORTED PATIENTS ONLY, Items 3-10. (TOTAL COUNTS) *2*3
Excludes Interfacility Transfers unless a critical intervention as specified under Item 8 was involved.**

For Items 3-10, please record the total number of patients in the space provided below for this reporting period that were treated and transported (see Appendix A for specific item definitions).

3. Provider Impression (Initial Assessment) When more than one Provider Impression is present, choose the one impression that precipitated and drove patient care decisions.	
Abdominal Pain/Problems	Electrocution
Airway Obstruction	Flu like Symptoms <small>(Chills/Fever/Dizziness/Weakness/Dehydration/etc.)</small>
Allergic Reaction	General Illness Not Otherwise Specified (NOS) *6
Altered Level of Consciousness *5	Hemorrhage/Bleeding
Behavioral/Psychiatric Disorder	Hypertension
Burns	Hyperthermia
Cardiac Arrest	Hypothermia
Cardiac Rhythm Disturbance	Hypovolemia/Shock
Cardiovascular Not Otherwise Specified (NOS) *6	Inhalation Injury (Toxic Gas)
Chest Pain/Discomfort	Medication Reaction
Congestive Heart Failure/Pulmonary Edema	Pain Not Otherwise Specified (NOS) *6*7
Diabetic Symptoms (Hypoglycemia)	Poisoning/Drug Ingestion
Digestive Symptoms (Nausea/Vomiting/Diarrhea)	Pregnancy/OB Delivery
Digestive Symptoms Not Otherwise Specified (NOS) *6	Respiratory Arrest
	Respiratory Distress
	Respiratory Not Otherwise Specified (NOS) *6
	Seizure
	Sexual Assault/Rape
	Smoke Inhalation
	Stings/Venomous Bites
	Stroke/CVA/TIA
	Syncope/Fainting
	Traumatic Injury Not Otherwise Specified (NOS)
	Vaginal Hemorrhage
	Other Not Otherwise Specified (NOS) *6
	Unknown

4. Cause of Injury *8 Choose up to 3 responses for this item per patient if an external cause of injury was involved under Item 3.	
Aircraft Related Crash	Fight or Brawl Unarmed
Animal Bite	Fire and Flames
Barotrauma (Scuba)	Firearm (Assault/Accidental Injury/Self Inflicted)
Bicycle (Rider/Passenger Injured)	Inhalation/Ingestion (Food, Beads, etc.)
Burn/Scald (Non-fire and Flame Related)	Lightning
Chemical Poisoning (Unintentional)	Machinery
Child Assaults	Mechanical Suffocation (Plastic Bag, Crib, etc.)
Diving Related Traumatic Injury (Excl. Scuba & Snorkeling)	Motorcycle (Cyclist/Cyclist Passenger Injured)
Drowning	Motor Vehicle Non-traffic (Off public Road or Highway)*9
Drug Poisoning (Unintentional)	Motor Vehicle to Bicycle-(Cyclist/Cyclist Passenger Injured)
Electrocution (Non-lightning)	Motor Vehicle to Fixed Object (Occupant Injured)
Excessive Cold	Motor Vehicle to Motorcycle (Cyclist/Passenger Injured)
Excessive Heat	Motor Vehicle to Motor Vehicle (Occupant Injured)
Fall (Unintentional)	Motor Vehicle to Pedestrian (Pedestrian Injured)
	Motor Vehicle/Train
	Motor Vehicle to Other
	Overexertion/Strain
	Radiation Exposure
	Rape
	Smoke Inhalation
	Stabbing Assault
	Struck by Object (Unintentional) NOS *6
	Venomous Bite/Stings (Plants/Animals)
	Water Transport
	Other Injury Not Otherwise Specified
	Not Applicable
	Unknown

5. Injury Site/Type (5A-Site/5B-Type) Choose up to 5 responses per patient if Item 3 was a trauma *10.		6. Patient's Age Category (Years)
A. Site of Injury (multiple response)	B. Type of Injury (Multiple response)	
External (Including burns)	Amputation	Under 1
Head Only (Excluding Neck, Cervical Spine & Ear)	Blunt Injury	1 through 4
Face (Including Ears)	Burn	5 through 14
Neck	Crush	15 through 54
Thorax (Excluding Thoracic Spine)	Dislocation/Fracture	55 through 64
Abdomen (Excluding Lumbar Spine)	Gunshot	65 through 74
Spine	Laceration	75 through 84
Upper Extremities	Pain without Swelling/Bruising	85 plus
Lower Extremities or Bony Pelvis	Puncture/Stab	Unknown
Body Region Unspecified	Soft Tissue Swelling/Bruising	

7. County of Incident		8. Critical Treatment/Intervention(s)? Choose as many responses as necessary for this item per patient.			
		<i>A. Treatments/Procedures Administered?</i>			
		AED Only Prior to Arrival Licensed EMS Provider		Intraosseous Catheter	
		AED & CPR Prior to Arrival Licensed EMS Provider		Intubation	
		AED Only by Licensed EMS Provider		Military Anti-Shock Trousers (MAST)/BP	
9. Patient's Highest Level of Care (Based of Treatment Level) By Mode of Transportation		AED & CPR by Licensed EMS Provider		Military Anti-Shock Trousers (MAST)/Fracture	
		Bag Valve Mask (BVM) w/o Intubation		Multi-lead Electrocardiogram (ECG)-3 Lead	
ALS Treatment Level By Ground		Blood Glucose Testing/Monitoring		Multi-lead Electrocardiogram (ECG)-12 Lead Plus	
ALS Treatment Level By Rotor Craft		Cardiac Pacing		Needle Thoracostomy	
ALS Treatment Level By Fixed Wing		Chest Tube		Nasogastric (NG)/Orogastric (OG) Tube	
BLS Treatment Level By Ground		CPR Only Prior to Arrival of Licensed EMS Provider		Obstetrical Care/Delivery	
Other		CPR Only by Licensed EMS Provider		Spinal/Cervical Immobilization	
10. Return of Spontaneous Circulation (ROSC) for Cardiac Arrest Patients		Cricothyrotomy		Volume Resuscitation (Fluid)	
		Defibrillation (Excluding AED)			
A. For Cardiac Arrest Patients in a Shockable Rhythm:		Yes	No	<i>B. Medication Administered?</i>	
AED admin. prior to arrival of EMS & ROSC present at ED transfer?				Aspirin for Chest Pain	Paralytic Drugs for Intubation
AED admin. by EMS and ROSC present at ED transfer?				Cardiac Drug(s) for Cardiac Care NOS *6 *11	Thrombolytics
No AED administered. and ROSC present at ED transfer?				Medication for Pain	
B. For Cardiac Arrest Patients Not in Shockable Rhythm:		Yes	No	<i>C. Alert Called (Hospital Notified Patient is En Route)?</i>	
ROSC present at ED transfer?				Cardiac Alert (Acute Myocardial Infarction)	Trauma Alert
				Stroke Alert	

Footnotes:

*1. A response/patient may only be counted once per category except under Part II for Items 4, 5, 8 which allow for multiple responses.

*2. Leave space blank when a particular item is not tracked by your agency and record a 0 if an item is tracked but did not occur during this reporting period.

*3. If necessary, an agency may group sub-category codes into a higher-level sub-category for reporting purposes. For example, different types of motor vehicle crashes may be collapsed into the sub-category General Motor Vehicle Crash. This modification must be noted and defined on the form.

*4. If multiple patients were evaluated at the scene they should be included in the total count for this part (e.g., 50 children evaluated from a school bus accident would be counted as 50 responses).

*5. Refers to patients with any altered level of consciousness not related to any other listed impression.

*6. NOS (Not Otherwise Specified) includes impressions not otherwise specified on provided list.

*7. Refers to incidents where pain NOS (e.g., head, neck, back, hip, extremity, generalized pain, etc.) was the single clinical impression that drove patient care. Excludes pain due to an external cause of injury or pain related to a specified illness or condition.

*8. Required when the "Provider Impression" under Item 3 was due to an external cause of injury.

*9. Motor Vehicle Non-Traffic Accident is any motor vehicle accident which occurs entirely in any place other than a public road. Note: A public road as defined in the 1989 ICD9/CM, refers to any road open to the use of the public for purposes of vehicular traffic as a matter of right or custom.

*10. A trauma means a blunt, penetrating or burn injury caused by external force or violence.

*11. Cardiac Drugs for Cardiac Care includes all cardiac drugs administered for Cardiac Care with the exclusion of Aspirin for Chest Pain, Paralytics and Medications for Pain Management.

*12. Record the total number of active staff hours worked in the reporting period.

Part 3 - EMS Provider Profile Information		<input type="checkbox"/> New (First time completing)		<input type="checkbox"/> Update (Change in provider information)	
This part only needs to be completed when Part I and or Part II of this form are completed for the first time or when there are changes in provider profile information. Please check the new or update box above to indicate whether the information recorded below is being completed for the first time or if the information being recorded is an update. This part must completed by all State of Florida licensed providers.					
1. Provider ID:		8. Counties and Cites of Operation (Include Areas with Mutual Aid Agreements):			
2. Provider Type:		/ / / /			
Contact:		/ / / /			
3. Name		/ / / /			
4. Mailing Address:		9. Zip Codes Covered (Include Areas with Mutual Aid Agreements):			
		/ / / /			
		/ / / /			
		/ / / /			
5. Phone Number: () -		10. Total Number of Active Staff Hours Worked *12		11. Total Number of Permitted Vehicles:	
6. Fax Number: ()		Paramedics: _____		Advanced Life Support (ALS) _____	
7. Email Address		EMTs: _____		Basic Life Support (BLS) _____	
		Other: _____		Air Rotor _____	
				Air Fixed Wings _____	
Reports are due to the Bureau of EMS quarterly as follows:		Send reports to*: Bureau of Emergency Medical Services		For assistance, comments or questions call:	
Quarter (based on date of incident)	Due:	Attention: Prehospital Aggregate Data Staff		EMS Aggregate Prehospital Data staff at	
Qtr 1- January 1 through March 31	4/30	4052 Bald Cypress Way, Bin C-18		(850) 245-4440	
Qtr 2- April 1 through June 30	7/30	Tallahassee, Florida 32399-1738		E-mail: EMSData@flhealth.gov	
Qtr 3- July 1 through September 30	10/30	* SEE FORM SUBMISSION REPORTING REQUIREMENTS BELOW			
Qtr 4- October 1 through December 31	1/30 (of the following calendar year)				

Form submission reporting requirements:

All forms must be readable and submitted to the Bureau of EMS on or in the same format shown in this document. Forms will be made available upon request at the address listed above and on the Bureau's web page. Aggregate data shall be submitted to the bureau using any medium, software, or by mail or hand delivery. Electronic submissions shall be made by using approved software, media or file format as specified by the Bureau of EMS. Electronic specifications will be made available upon request.